STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED	
		155409	A. BUILDING B. WING		07/25/2011	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			ı	KEYSTONE AVENUE		
WATERS	OF INDIANAPOLI	S, THE		IAPOLIS, IN46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
		1.5	170000	B		
	_	ode Recertification and	K0000	Preparation and/or executi of this plan of correction i	I	
		Survey was conducted by		general, or this corrective	"	
		Department of Health in		action in particular, does n	ot	
	accordance with	42 CFR 483.70(a).		constitute an admission or	I	
				agreement by this facility of	of the	
	Survey Date: 07	7/25/11		facts alleged or conclusion	ıs	
				set forth in this statement	of	
	Facility Number	: 000537		deficiencies. The plan of		
	Provider Numbe			correction and specific	a u a d	
	AIM Number: 100267270			corrective actions are prepared and/or executed in complia	I	
	711171 Tullioof. 100207270			with state and federal laws		
	Surveyor: Mark Caraher, Life Safety					
	Code Specialist					
	At this Life Safe	ty Code survey, The				
	Waters of Indian	apolis was found not in				
		Requirements for				
	•	Medicare/Medicaid, 42				
	•	3.70(a), Life Safety from				
	*	0 Edition of the National				
		Association (NFPA) 101,				
		e (LSC), Chapter 19,				
	Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to					
	be of Type V (000) construction and fully					
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and					
	has battery opera	ated smoke detection in				
	all resident sleeping rooms. The facility					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

NX3P21

Facility ID:

000537

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
155409		B. WING			07/25/2	011	
NAME OF PROVIDER OR SUPPLIER  WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP CODE  3895 S KEYSTONE AVENUE INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	has a capacity of 81 and had a census of 47 at the time of this visit.  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/28/11.  The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		PRE	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
V.0020							
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are equipped with functioning self closing devices. This deficient practice could affect any resident, staff or visitor in the vicinity the housekeeping office.  Findings include:		K002	29	K029– It is the intent of the faci to ensure all doors serving hazar areas such as storage rooms greathan 50 square feet in size that a used to store combustible mater are equipped with functioning sclosing devices  1. ACTIONS TAKEN:  A. A properly functioning se closer has been installed on the housekeeping office door.	rdous ater are ials elf	08/20/2011

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Event ID:

NX3P21 Facility ID:

000537

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155409 07/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVENUE WATERS OF INDIANAPOLIS, THE INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on observation with the 2. OTHERS IDENTIFIED: Maintenance Director during a tour of the All residents would have the facility from 10:40 a.m. to 12:30 p.m. on potential to be affected. 07/25/11, the housekeeping office All rooms over 50 square feet that measured 100 square feet and is used to are used to store combustible material have been checked and have store combustible housekeeping supplies proper functioning self closing in cardboard boxes and is equipped with a devices in place. self closing device on the entry door but 3. SYSTEMS IN PLACE: the arm on the self closing device was not in place. Based on interview at the time A. Self closing doors were added to preventative maintenance weekly of observation, the Maintenance Director program. stated the housekeeping office is additionally used to store combustible 4. HOW MONITORED: housekeeping supplies and acknowledged the housekeeping office was greater than A. The Director of Maintenance/Designee will complete fifty square feet in size with an entry room audit checks and report findings in door not equipped with a functioning self monthly QA meetings closing device. B. The CEO/Designee will review all QA audits as completed in 3.1-19(b) monthly QA meeting. C. The CEO/Designee will review monthly in QA meeting; and quarterly in QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: August 20, 2011.

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155409	A. BUI	LDING	01	07/25/2	
		155409	B. WIN			0772372	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF INDIANAPOLIS	S THE		1	KEYSTONE AVENUE APOLIS, IN46227		
			_	<u> </u>	711 OLIO, 11440227		ars)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K0076 SS=E	are protected in ac Standards for Hea	ge and administration areas accordance with NFPA 99, alth Care Facilities.					
	separation.	closed by a one-hour upply systems of greater					
	than 3,000 cu.ft. a NFPA 99 4.3.1.1.2	re vented to the outside.					
	Based on observa	ation and interview, the	K(	K0076	<b>K076</b> – It is the intent of the fact	-	08/20/2011
	· -	ensure 1 of 1 oxygen			that all medical gas be stored ar administered in areas protected		
	storage locations	of greater than 3000			accordance with NFPA 99, Stan		
	cubic feet was:				for Health Care Facilities.		
	1) separated fron	n any portion of a facility					
		s are housed, examined,			1. ACTIONS TAKEN:		
	1	eparation of a fire barrier			All respiratory supplies were		
	of 1 hour fire resistive construction.				removed from the oxygen and		
	2) separated fron	n a minimum distance of			transfilling room on 07-27-11.		
	at least five feet	from combustible			A second layer of five eighths in		
	materials.				drywall was installed on 8-9-20	11.	
	NFPA 99, 8-3.1.1	11.2(c) requires oxidizing			2. OTHERS IDENTIFIED:		
	gases such as oxy	ygen shall be separated			A. All residents have the poter	ntial	
	from combustible	es by a minimum			to be affected by this practice.		
	distance of five f	eet if the required storage			· •		
		cted by an automatic			3. SYSTEMS IN PLACE:		
	sprinkler system. This deficient practice				A. There are no other oxygen	and	
	could affect any	could affect any resident, staff or visitor in the vicinity of the oxygen storage and			transfilling rooms in the facility		
	the vicinity of the				oxygen room was added to the		
	transfilling room	-			preventative maintenance week rounds to ensure it is maintained	-	
	Findings include						
	Based on observation with the				4. HOW MONITORED:		
		ector during a tour of the			A. The Director of		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 01		01	COMPLETED	
	155409		B. WIN	IG		07/25/2011	
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					KEYSTONE AVENUE		
WATERS	OF INDIANAPOLIS	S, THE		INDIANAPOLIS, IN46227			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	facility from 10:4	40 a.m. to 12:30 p.m. on			Maintenance/Designee will con		
	07/25/11, the oxy	gen storage and		weekly audits and report findings in	gs in		
	transfilling room	contained one liquid			monthly QA meetings.		
	oxygen canister a	and twenty eight oxygen			B. The CEO/Designee will rev	iew	
		ch containing 679 liters of			all weekly audits results in mon		
	oxygen. The oxy	•			Q.A. meeting.	,	
		had a ceiling with one			-		
	_	ths inch thick drywall.			C. The CEO/Designee will revi	ew	
		six foot tall storage			monthly in QA meeting; and		
	· ·	•			quarterly in QA meeting with the	ne	
		ng boxes of respiratory			Medical Director.		
		ng stored within five feet					
	of the liquid oxygen canister and the				5. This plan of correction		
		corage tanks. Based on			constitutes our credible allega	tion	
		ime of observation, the			of compliance with all regulate		
	Maintenance Director acknowledged the ceiling did not provide 1 hour fire resistive construction and combustible materials were stored within five feet of				requirements.		
					Our date of compliance is: Au	igust	
					20, 2011.		
		the liquid oxygen canister and the oxygen					
	storage tanks.						
	2.01.00 turing.						
	3.1-19(b)						
	J.1-19(U)						

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155409	(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  07/25/2011		
NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE			STREET ADDRESS, CITY, STATE, ZIP CODE  3895 S KEYSTONE AVENUE INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
K0143 SS=E	Transferring of oxy  (a) separated from wherein patients a treated by a separ 1-hour fire-resistive  (b) in an area that sprinklered, and he flooring; and  (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas. Based on observer facility failed to oxygen storage a oxygen takes plath 1) separated from wherein residents or treated by a set of 1 hour fire rest 2) in an area have flooring.  3) in an area post transferring of oxygen storage are of 1 hour fire rest 2 in an area post transferring of oxygen storage and transferring and transferring and transferrin	rgen is:  any portion of a facility re housed, examined, or ation of a fire barrier of e construction;  is mechanically ventilated, as ceramic or concrete  ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 ation and interview, the ensure 1 of 1 liquid reas where transferring of the was: any portion of a facility are housed, examined, paration of a fire barrier istive construction. and ceramic or concrete  and with signs indicating tygen is occurring. actice could affect and visitors in the vicinity orage and transfilling	K0143	K143— It is the intent of the facto ensure that transferring of ox is completed in an area that is separated by a 1 hour fire resist construction., with proper floor and posted with proper signage  1. ACTIONS TAKEN:  A second layer of five eights indrywall was installed on 8-9-20 Vinyl flooring was removed on 8-2-2011.  Signage indicating transfilling voccurring was immediately placed door.  2. OTHERS IDENTIFIED:  All residents would have the potential to be affected.  3. SYSTEMS IN PLACE:  A. There are no other oxygen	ility ygen ive ing ch ill. was eed on		

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l '		IDENTIFICATION NUMBER:	A. BUILDING	01	(X3) DATE SURVEY  COMPLETED		
		155409	B. WING		07/25/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVENUE				
	OF INDIANAPOLIS			IAPOLIS, IN46227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	facility from 10:4 07/25/11, the oxy transfilling room oxygen canister, layer of five eigh had vinyl floorin posted with signs transferring of ox Based on intervice observation, the stated the facility oxygen in the roo and acknowledge provide 1 hour fi the flooring was and this area not	40 a.m. to 12:30 p.m. on ygen storage and contained one liquid had a ceiling with one aths inch thick drywall, g and the area was not indicating the exygen occurs in the room. It is inched the time of the system of the system occurs in the room. It is indicating the exygen occurs in the room. It is indicating the exy		transfilling rooms in the facilit oxygen room was added to the preventative maintenance week rounds.  4. HOW MONITORED:  A. The Director of Maintenance/Designee will coweekly audits and report finding monthly QA meetings.  B. The CEO/Designee will reall QA audits as completed in monthly QA meetings.  C. The CEO/Designee will rewently in QA meeting; and quarterly in QA meeting with Medical Director.  5. This plan of correction constitutes our credible allegation of compliance with regulatory requirements.  Our date of compliance is: A 20, 2011.	mplete mgs in view the		